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An AIDS Diagnosis Used as Focus of Malingering

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PSYCHIATRIC DISORDERS are often associated with medical problems or are offered by a patient or physician as an explanation of "medical" symptom complexes.[1,2] A medical evaluation usually and appropriately ensues to explain a patient's symptoms, but a serious consideration of psychiatric diagnoses is often delayed.[3,5] The acquired immunodeficiency syndrome (AIDS) is a new syndrome caused by the human immunodeficiency virus (HIV) and marked by uncommon infections, neoplasms, and other still poorly defined disorders. We present a patient with AIDS who indicated he had symptoms attributable to an organic disease but who ultimately was diagnosed as having a psychiatric disorder in which he was using his AIDS diagnosis to meet other psychosocial needs.

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ABBREVIATIONS USED IN TEXT

AIDS = acquired immunodeficiency syndrome
CT = computed tomographic
HIV = human immunodeficiency virus
VAMC = Veterans Administration Medical Center

Report of a Case

A 29-year-old homosexual man was admitted to the Denver Veterans Administration Medical Center (VAMC) with new, progressive, left-sided weakness. The patient reported that he had recently moved from Texas where a diagnosis of AIDS had been made. He said he had had numerous opportunistic infections including *Cryptococcus, Pneumocystis,* and cryptosporidiosis. He had received several experimental drugs, including suramin sodium and difluoromethylornithine (DFMO). He brought numerous records with laboratory and diagnostic test results that were positive only for an elevated cytomegalovirus titer. There was no record of an HIV titer.

He reported having increasing left hand weakness about two weeks before admission. Six days before admission, he experienced a stabbing, bilateral temporal headache. He presented to the Denver VAMC six days later. The left-sided weakness had gradually increased to the point of difficulty in holding objects. The headache was accompanied by a brief episode of loss of consciousness. This was followed by nausea, dizziness, confusion and disorientation, and left arm and leg paralysis. The patient also described transient diplopia and a central scotoma.

The patient said he did not have auras, apraxias, incontinence, tonic-clonic movements, drug use, a history of a similar episode, or a history of diabetes mellitus. He had had numerous electroencephalograms in the recent past that were reportedly normal. He had no known allergies and was currently taking no medication. He had attempted suicide in 1984 with an amitriptyline overdose. He had hepatitis in 1976 and genital herpes of an uncertain duration. The patient was an unemployed chauffeur who lost his job after being diagnosed with AIDS. He had a 15-year history of promiscuous homosexual activity. He smoked cigarettes and used alcohol and marijuana occasionally. He said he did not use drugs intravenously.

He was muscular and appeared healthy. There was no fever, his blood pressure was 110/70 mm of mercury, respiratory rate 12 per minute, heart rate 90, weight 93 kg (205 lb), and height 190 cm (6'3"). He had a gold circular earring in his left nipple. The neurologic findings varied with the observer. Cranial nerves I through XII were completely intact except for a weak right sternocleidomastoid muscle. There was a false-positive orbicularis oculi test. Motor strength on the right was normal, but all muscle groups tested in the left upper and lower extremity were weak (0 to 4/5). He was able to stand and walk on both heels and toes. Muscle tone was notably increased in all groups tested with active resistance to movement, relaxed with persistence, and then was normal. A sensory examination showed no abnormalities. Deep tendon reflexes were normal. Cerebellar function was normal except for the left extremities, which could not be tested. He had a leukocyte count of 5,200 per μl with a normal differential, and the sedimentation rate was 11 mm per hour. The platelet count, prothrombin time, and other routine laboratory tests were normal.

Because he was relatively well and because of the inconsistent findings of the examination and laboratory data, we elected to not embark on an emergent diagnostic workup until additional historical information was obtained. A call to the hospital in Texas revealed that his records were lost.

A call to a physician who reportedly knew the patient well yielded a vague history that the patient may have been positive for HIV and that he had diarrhea at one time that resolved and may have been due to cryptosporidiosis. On neurologic consultation, the conclusion was that the symptom complex and history were not consistent with a seizure, migraine, or a typical cerebrovascular accident. The lack of sensory findings was thought to be inconsistent with a hysterical cause. At the request of the neurology service, a computed tomographic (CT) scan and lumbar puncture were done. The CT scan was normal except for a suggestion of mild cerebral atrophy. The spinal fluid was clear; there were three erythrocytes and three leukocytes (all lymphocytes); a cerebrospinal fluid glucose level was 54 mg per dl (serum glucose 80) and protein 29 mg per dl; india ink, acid-fast, and Gram's stains were negative; cryptococcal antigen, VDRL, and cultures were negative.

The patient requested to be put on a status of no resuscitation in the event of cardiopulmonary arrest and to be seen by the psychiatric service. The psychiatrist noted that the patient exaggerated and embellished symptoms, but the psychiatrist did not think the findings could be totally due to fabrication.

The patient's sister was contacted, and she corroborated the AIDS history but gave us no new or additional objective data. On the third day of admission, the neurology service staff obtained some additional history. The patient was living with a woman with left-sided weakness who used a wheelchair to get around. He had also been scheduled to appear in court on the day of admission and was worried about his financial and housing situations. His move from Texas was not precipitated by this illness, as the patient had initially reported, but rather by his being evicted from his home due to his refusal to work. He had worked on a psychiatric service in the past.

The patient was transferred to the neurology service. A magnetic resonance imaging scan and an electroencephalogram were done and were normal. A serum HIV test by the enzyme-linked immunosorbent assay and Western blot methods was positive. The patient was discharged before an interview using thiopental sodium could be done.

Discussion

The differential diagnoses to explain this patient's symptoms include various central nervous system conditions associated with AIDS and three psychiatric disorders—factitious disorder, malingering, and conversion reaction. Factitious disorders and malingering are two disorders in which patients voluntarily control their particular symptom complex. Malingering is usually characterized by a recognizable motivating goal for the presentation. Factitious disorders are characterized by underlying psychopathology where the motivating goal is involuntarily adopted and not recognizable or known to the patient or observers. A diagnosis of malingering should be considered especially for any of the following reasons: there is a medicolegal aspect to the presentation; there is a pronounced discrepancy between the subjective complaints and the objective findings; there is a lack of cooperation; or the patient has an antisocial personality disorder.[6(pp285-290,331-332)]

Conversion reactions, in contrast to the above, are characterized by symptom complexes that are under involuntary control. The physical disorder is apparently an expression of a psychological conflict or need. Symptoms are most often neurologic. Those with conversion reactions often have relief of symptoms with hypnosis, suggestion, or the intravenous administration of barbiturates; this is not the case with malingering.[6(pp244-247)]

This patient was HIV positive but did not have a recognizable pathophysiologic process to explain his symptoms. This was confirmed by extensive consultation and diagnostic evaluations. We became convinced, therefore, that our patient had a psychological disorder. It appears that the physical findings were under voluntary control (malingering or factitious disorder), suggested by the inconsistent findings on examination and the pseudopareses of his cranial nerves. The diagnosis of malingering also is suggested by the recognizable motivating goals: avoiding a court date and a less-than-adequate living situation with notable financial difficulty. A conversion reaction, under involuntary control, might have been even more convincingly ruled out if a thiopental interview had been done.

This patient with an unconfirmed history of AIDS presented with what initially appeared to be a serious symptom complex. It is certainly appropriate to consider the very severe pathophysiologic causes of any such finding in a patient with AIDS. These patients, however, may also acquire psychiatric disorders at least as frequently as other patients or use their AIDS diagnosis for other psychosocial purposes. The increasing number of AIDS patients will continue to face issues of safety, segregation, and prejudice, but the medical profession has the responsibility to diagnose and treat all members of society. A careful clinical evaluation and consideration of the differential diagnosis, including psychiatric disorders, should lead to the correct diagnosis in these patients. A biopsychosocial approach will decrease inappropriate diagnostic testing and improve the outcome for these patients.

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